The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://knowyourbenefits.dfa.ms.gov or call 1-800-709-7881. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-709-7881 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network & Out-of-network: $1,800/individual; $3,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care in-network is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Preventive prescription drugs: $75/individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network providers: $6,500/individual; $13,000/family. Out-of-network providers: no out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain prior approval.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers see: http://knowyourbenefits.dfa.ms.gov or call 1-800-294-6307.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance.	40% coinsurance.	Primary care telemedicine: $10 (Subject to Deductible)
	Specialist visit			
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	40% coinsurance.	
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myprime.com	Generic drugs	Retail: $12 copay. Mail order: $24 copay.	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay.	Separate preventive prescription drug deductible of $75/individual (for certain preventive medications) if the Base coverage deductible has not been met. Mail Order Quantity: 90-day supply. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate or unavailable). If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug, plus the generic copay. Certain prescriptions require prior approval.
	Preferred brand drugs	Retail: $45 copay. Mail order: $90 copay.		
	Non-preferred brand drugs	Retail: $100 copay. Mail order: $200 copay.		
	Specialty drugs	Retail: $100 copay.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	40% coinsurance.	
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance.	40% coinsurance.	
	Urgent care	20% coinsurance.	40% coinsurance.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance.	40% coinsurance.	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than 5 days before admission (or more than 48 hours after emergency admission): $250.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	40% coinsurance.	
	Inpatient services	20% coinsurance.	40% coinsurance.	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than 5 days before admission (or more than 48 hours after emergency admission): $250.
If you are pregnant	Office visits	20% coinsurance.	40% coinsurance.	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance.	40% coinsurance.	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	40% coinsurance.	Certification required.
	Rehabilitation services	20% coinsurance.	40% coinsurance.	Certification required.
	Habilitation services	20% coinsurance.	40% coinsurance.	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance.	40% coinsurance.	Certification required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance.	40% coinsurance.	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance.	40% coinsurance.	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered.	Not covered.	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease)
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (prior approval required)
- Chiropractic services (limited to 30 visits/individual/year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (prior approval required)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact Health Help Mississippi at 1-877-314-3843 or healthhelpms@mhap.org.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$60
Coinsurance	$2,130
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$4,000

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,050
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$2,050

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$50
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,880

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please call 1-866-939-4721.

The plan would be responsible for the other costs of these EXAMPLE covered services.